California Health Policy and Data Advisory Commission
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Minutes
California Health Policy and Data Advisory Commission
October 12, 2007

The meeting was called to order by Vito Genna, Chair, at approximately 10:00 a.m., at the Hotel Solamar, San Diego. A quorum of half of the members plus one was in attendance.

Present:	**Absent:**
Vito J. Genna, Chairperson	Howard L. Harris, PhD
William Brien, MD	Kenneth M. Tiratira, MPA
Marjorie Fine, MD	Sol Lizerbram
Janet Greenfield, RN	Jerry Royer, MD
Adama Iwu	Josh Valdez, DBA
Corinne Sanchez, Esq.	

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

OSHPD Staff: David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Counsel; Patrick Sullivan, Assistant Deputy Director, Legislation and Public Affairs; Michael Rodrian, Deputy Director, Healthcare Information Division; Joseph Parker, PhD, Director, Health Quality and Analysis Division; Jonathan Teague, Manager, Healthcare Information Resources Center; Mary Tran, PhD, MPH, Administrative Data Programs; Michael Byrne, ITSS; Maria Giuriato, Executive Director, Health Professions Education Foundation; Glenn Padayachee, MA, Director of Programs Administration, Health Professions Education Foundation

Approval of Minutes: A motion was made by Commissioner Fine and seconded by Commissioner Greenfield to approve the minutes of the August 24, 2007 meeting. The motion was carried.

Health Data and Public Information Committee Report: Kathleen Maestas, Acting Executive Director, CHPDAC

Acting Executive Director Maestas reported that the main purpose of the September Health Data and Public Information Committee (HDPIC) meeting was to bring

committee members up to speed on the activities and presentation given at the last two California Health Policy and Data Advisory Commission meetings and the last AB 524 Technical Advisory Committee meeting. Dr. Carlisle reported that the main topic in California remains healthcare reform and the Governor has called a special session to work on healthcare reform. There is a competing initiative to the Governor's proposal, AB 8, by Speaker Nunez. One of the most significant differences between the two proposals is that AB 8 requires a 7.5 percent provider fee, and the Governor's proposal requires a 4 percent provider fee.

Acting Executive Director Maestas reported that Anne McLeod, representing the California Hospital Association, was asked to comment at the HDPIC on the progress of healthcare reform. Ms. McLeod reported that CHA had been working with the Governor's Office and had come to an agreement of elements of healthcare reform as they relate to the finance portion.

The California Hospital Association Board of Trustees did agree to a 4 percent provider fee on hospitals, the fee being based off of the hospital's aggregate net patient revenue, and then through different financial models the CHA had determined that the fee would be assessed on individual hospitals based on a certain amount of their patient base.

There would be two separate fees, one for the managed care days and one for the service days. Medicare days would be deducted, as well as long-term days. Rural hospitals with 50 beds or less, and district hospitals with 300 beds or less would not be subject to the fee. These fees should raise approximately $1.7 billion from the private, nondesignated public hospitals.

Chairperson's Report: Vito Genna, Chair

Chairperson Genna stated that from an employer's perspective, there are a number of significant issues that come into play in regards to healthcare reform, especially for employers who already pick up a large portion of healthcare insurance in addition to providing vacation time and sick leave. Couple this with disability benefits going up January 2008, and employers will have to face difficult decisions when it comes to increasing benefits or pay.

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

OSHPD Director, Dr. Carlisle, distributed a synopsis of the changes that have occurred with the Governor's Healthcare Reform proposal since January to the Commissioners. Universal coverage has not changed significantly between the January proposal and the most current press release with some notable exceptions:

- The Tax credit is now proposed for individuals and families, between 200 and 350 percent of the Federal Poverty Level (FPL), which represents a significant improvement in affordability.
- The two percent physician fee has been eliminated. In exchange for that fee, which would have netted almost $2 billion, there is a bill that proposes a contribution from the California Lottery currently being introduced.

- A sliding scale has been introduced for employers, for zero percent of payroll up to four percent. This represents a significant difference between the Governor's proposal and the Perata/Núnez proposal which calls for a 7.5 employer contribution.
- The original $1 billion in county funds for public hospitals and healthcare systems has been augmented by an additional $500 million.
- The minimum benefit will now be deferred to the Health and Human Services Secretary, who will determine the benefit package once the proposal has been enacted.

Commissioner Fine asked if the Health and Human Services Division has addressed what form the individual mandate for health insurance would be take, a high deductible policy or first-dollar coverage.

Dr. Carlisle stated that to his knowledge the actual formulations have not been discussed, but that one has to acknowledge that there certainly is a market for high deductible policies which reduce premium costs significantly.

Commissioner Fine made the observation that if a high deductible policy was made available, an individual could opt for this policy, but not be able to pay the first $5,000.

Dr. Carlisle stated that this would be entirely possible, but that many of those individuals might also be in the financial category where they could receive direct subsidies, or benefits from tax credits, as well.

One of the characteristics of the Governor's proposal, that makes it quite different from any other proposal, conceptually, is that it does not change or rearrange the building blocks in the healthcare delivery system, but essentially improves them and makes them more efficient in a variety of ways.

There are two competing bills currently before the Governor. The first is SB 840, by Senator Sheila Kuhl, that is a single-payer legislation that has been previously introduced and passed; it was vetoed by the Governor and he has promised to veto this bill again.

There is also AB 8, by Speaker Nunez, which is a "play or pay" bill that the Governor has also promised to veto [this has since happened]. AB 8 is of particular significance to the Office as it was recently amended to add language which proposes creating a new commission within the Health and Human Services Agency to which all the data-out functions that currently exist within OSHPD would be transferred. In contrast to AB 8, the Governor's proposal calls for increasing the activities that currently exist in the way of outcome, quality and transparency reporting.

The Office has had conversations with individuals and organizations about the new language contained in AB 8. The organizations involved in drafting this language are SEIU, Consumers Union, Pacific Business Group on Health, AARP, and Health Access. These organizations have expressed significant concern over the Office's progress in producing risk-adjusted outcomes studies.

The original AB 524 language required the Office to produce 18 risk-adjusted outcome studies by 1995. The Office has never hit that mark, in part as a consequence of the Technical Advisory Committee's advice that the Office not proceed with the program's existing risk-adjustment methodology, as it was considered to be inaccurate and producing misleading results. The TAC charged the Office with redesigning an auditing and data validation system to support the risk-adjusted outcome studies which has resulted in a total of 21 public reports being produced to date.

Commissioner Fine asked that in regard to the risk-adjusted outcome studies that the Office has been found deficient in producing, did these organizations suggest that it would be better to provide inaccurate data and more reports. "It seems that it was an essential part of the maturation of the computer system and the collection system to then assure the accuracy of the materials that were forthcoming from the Committee. To say that you need to generate X number of reports within a period of time, when your collection system was antiquated or inappropriate doesn't seem to meet the needs of the State."

Dr. Carlisle stated that that is really the crux of the issue. There are alternative reporting systems. For example Pennsylvania uses a proprietary, black box risk-adjustment methodology, whose workings are not transparent, versus the relatively transparent methodology that OSHPD has relied upon, where it is clear which variables weigh into the risk-adjustment model.

Dr. Parker commented that a lot of states report risk-adjusted mortality rates using the Agency for Healthcare Research and Quality Measures (AHRQ); eight medical conditions and seven medical procedures. OSHPD finds the risk-adjusted algorithm used to be problematic, in that it gives more credit to hospitals that have complications of care. The majority of databases in this country do not distinguish between complications and pre-existing conditions; consequently, without the present on admission indicator which OSHPD uses, they are taking advantage of a methodology which is inherently flawed.

Legislative Report: Patrick Sullivan, Assistant Deputy Director, Legislation and Public Affairs

Assistant Deputy Director, Patrick Sullivan reported that 5 bills that impact OSHPD did reach the Governor's Office.

AB 1559, by Assembly Member Berryhill, seeks to address the ongoing nursing shortage issue by improving the admissions process for community college nursing programs. The issue prompting this legislation is that many of the community colleges have been using a lottery type admissions process and the dropout rate for their nursing programs has been between 25 to 40 percent as compared to the UC's criteria-based screening process where the dropout rate is around 11 percent. This bill could potentially add 2,000 more nurses to the workforce by moving community colleges to use a more criteria based admissions process. The Governor has not taken action on this bill at this time.

SB 139, by Senator Scott, represents a reintroduction of the bill he introduced last year which aims at getting information on healthcare workforce from a centralized location. This bill has been signed by the Governor and will now represent a significant program for OSHPD's Healthcare Workforce Development Division and Healthcare Information Division. These Divisions will work together with the different entities to collect information on the educational employment trends in healthcare workforce and become the central warehouse for all workforce data.

SB 306, by Senator Ducheny, has two elements which impact OSHPD's Facility Development Division. One element is to implement a streamlined approach for OSHPD's plan review process shortening the time by six months. The second element represents a departure from normal operations in OSHPD's seismic safety program by implementing an extension to SPC-1 hopitals that can prove financial difficulty in retrofitting their building. The Governor has not taken action on this bill at this time.

SB 615, by Senator Oropeza, would require a mandatory $10 fee to cover the pharmacy technician loan repayment program. The Governor has not taken action on this bill at this time.

SB 764, by Senator Migden, was a bill to do a five-year projection on primary care physician and surgeon workforce. The Governor has vetoed this bill.

Commissioner Fine asked if the same information cover by SB 139 was not in fact also available through the State licenses.

Commissioner Iwu stated that the information contained is not readily accessible and does not provide ancillary information such as where they practice, whether they are full or part-time and what their cultural competencies are.

Dr. Carlisle asked Healthcare Workforce Development Division Deputy Director, Angela Minniefield to comment on SB 139. Division Deputy Director, Minniefield stated that from a health education and research stand points, the Healthcare Workforce Clearinghouse will give California an opportunity to highlight what the workforce shortages are, and to reasonably assess the status of California's health workforce. The Healthcare Workforce Clearinghouse will provide an opportunity to centralize the location of data from a variety of sources and then help to inform policymakers, as they strive to develop programs to meet the workforce needs and demands of California.

<u>Healthcare Workforce Development Division Report:</u> Angela Minniefield, Deputy Director

The Healthcare Workforce Development Division (HWDD) supports healthcare accessibility through the promotion of a diverse and competent healthcare workforce, and provides analysis of California's healthcare workforce infrastructure. The Division has a number of components including the Shortage Designation Program, the Health Careers Training Program, the National Health Service Corp State Loan Repayment Project, and the Song-Brown Program.

HWDD has a variety of programs that support a healthcare pathways continuum which are focused on outreach, career development and placement. The outreach component involves staff outreach to high schools, community colleges, State universities and UCs to share with students the opportunities available in healthcare. Within the career development component, HWDD supports residency programs and graduate training programs, provides mini-grant support to post-baccalaureate programs and interacting with local and regional collaborates to talk about opportunities, and develop partnerships for training future providers in medically underserved areas of the State. The last component involves placement where HWDD focuses on recruitment and retention of providers in underserved areas of the State.

The Song-Brown Program was mandated in 1973 with the goal of increasing the number of primary care providers in underserved areas of California, to improve the quality and training of providers, as well as improving access of care to California's underserved and multi-cultural communities. The Song-Brown budget is approximately $6.6 million annually, which is funded by both the General Fund and the California Health Planning and Data Fund. The funds support institutions, not individuals, which provide clinical training for family medicine residents, nurse practitioners, physician assistants and registered nurses. In California the Song-Brown Program currently supports 27 of 42 family practice residency programs, three of the eight physician assistant programs, nine of 12 family nurse practitioner programs and 21 of 107 registered nurse education programs.

The Health Workforce Pilots Project Program studies the expansion of a profession's scope of practice and is also used to amend or modify regulations. To illustrate how this program works, in 1978, the role of registered nurses was actually expanded utilizing the Health Workforce Pilot Project as a vehicle to see whether it was possible to expand the profession's scope of practice, which is how the nurse practitioner role emerged. Similarly, in 1997, the role of the registered dental hygienist emerged out of a Health Workforce Pilot Project.

The National Health Service Corp State Loan Repayment Program is set up to repay education loans of health providers for their commitment to serve in health professions shortage areas. Typically, the National Health Service Corp State Loan Repayment Program received a Federal grant of approximately $1 million annually. In program year 16, the funding was cut by about 47 percent. It was then reauthorized, but as with other Federal Title VII programs, this program has been experiencing some volatility in terms of its annual budget.

The Shortage Designation Program was enacted by Congress in the 1970s through the Public Health Service Act. HWDD receives reviews and recommends health professional shortage areas (HPSA) in California for designation to Health Resources and Services Administration's (HRSA) Shortage Designations Branch. The HPSA designation afford healthcare facilities increased recruitment, retention, and funding opportunities.

Deputy Director Michael Rodrian added that this highlights exactly how "geography–driven" these data sets are, especially moving down to the subcounty areas. Federally

qualified health centers are identified and approved based on shortage areas and become eligible for cost-based reimbursement for services.

The Health Careers Training Program was established in the late nineties with the goal of strengthening the health industry by developing a culturally and linguistically competent healthcare workforce. This program facilitates training of under represented individuals for health professions that are needed in underserved areas of California, assists educators and healthcare providers in developing and expanding occupational training for targeted health professions, and provides support, through mini-grants, for programs that are focused on academic preparation.

Recently HWDD has created a research unit which has been involved in developing a fact book for health workforce issues that highlights health workforce issues in California. The fact book will actually provide national and State population data, demographic and growth trend data, health workforce data and will identify where health professional training programs are available in California, including an overview of HWDD's programs. The current release date for the fact book is January.

Health Professions Education Foundation Report: Glen Padayachee, MA, Director of Programs Administration (SSM II)

The Health Professions Education Foundation (HPEF) is a non-profit public benefit corporation which was created by the Legislature in 1987. The HPEF is governed by a 13 member Board of Trustees and receives administrative support from OSHPD.

The mission of HPEF is to increase the number of healthcare professionals providing direct care in medially underserved areas (MUAs) of California through scholarships and loan repayments to health professional students and graduates and to increase the number of demographically underrepresented and economically disadvantaged students practicing health professions.

The HPEF has a number of programs with awards ranging from $2,000 up $105,000 and which require a MUA service obligation between 1 and 3 years. In addition all programs have the following eligibility requirements:

- Applicants must present documentation of their financial need
- Applicants must submit "official transcripts"
- Applicants must submit 2 letters of recommendation
- Health-related work experience, community background, career goals, community involvement, and academic performance

The HPEF administers the following programs:

- The Associate Degree Nursing Scholarship Program and the Pre-Nursing Scholarship Program aim to increase the number of registered nurses practicing in MUAs of California

- The Bachelor of Science Nursing Scholarship Program which aims to increase the number of appropriately trained professional nurses and to encourage their practice in direct patient care in MUAs of California
- The Allied Healthcare Scholarship Program aims to increase the number of appropriately trained allied healthcare professionals in the fields of medical imaging, occupational therapy, physical therapy, respiratory care, social work, pharmacy, pharmacy technician, medical laboratory technologist, surgical technician, ultrasound technician, and diagnostic medical sonography
- The Health Professions Education Scholarship Program and the Health Professions Education Loan Repayment Program aim to increase the number of dentists, dental hygienists, nurse practitioners, certified midwives, and physicians assistants who are practicing direct patient care in MUAs of California
- The Steven M. Thompson Physician Corps Loan Repayment Program aims to increase the number of culturally and linguistically competent physicians who are practicing in MUAs of California
- The California's Vocational Nursing Scholarship and Loan Repayment Programs offers three types of vocational awards: Vocational Nurse Scholarship, Licensed Vocational Nurse to Associate Degree Nurse Scholarship and Licensed Vocational Nurse Loan Repayment Program, all of which aim to increase the number of vocational Nurses practicing in MUAs of California

Funding for specific programs comes from the Licensed Registered Nurse Education Fund, the California Endowment, Kaiser Permanente, voluntary physician license renewal fees and by private donations, with applicants being awarded in March and September. The progress of applicants receiving awards is monitored on a monthly basis by program administrators, and every quarter applicants are required to submit documentation showing that they are still working in the MUA authorized or assigned by their superior. If the applicant is in school, a transcript is required to show they are maintaining the required grade point average (GPA).

Commissioner Greenfield ask if the original legislation for collecting the $10 fee from nurses was specifically intended to fund underserved areas only?

Deputy Director Minniefield stated that Senator Maddy wrote the legislation creating the Registered Nurse Education Program to accomplish two goals; first, to help address California's nursing shortage, and second, to increase the number of under represented students that are actually practicing nursing. In 2000, this legislation was linked to the under-served areas.

Commissioner Greenfield stated that she is shocked that nurses are giving money that only serves the designated underserved areas when she perceives the entire state as underserved.

Deputy Director Minniefield stated that further legislation by Senator Escutia, did expand the definition of underserved, particularly for registered nurses, and included the county facilities and the State-operated health facilities. So while the shortage areas are the considered the areas with the highest degree of need, there is recognition that California faces a statewide shortage.

Commissioner Greenfield stated that her concern was in the designation of where nurses were sent. "You are saying that you are going to a State hospital and you are going to a county hospital, but that does not mean that the private sector does not need nurses just as badly and that is where the money is coming from. The money is coming from nurses." Nurses who are making the contribution should know the full extent of that program.

Assistant Deputy Director Sullivan stated that the fee issue has been a politically difficult issue. There have been a number of other student loan repayment programs introduced in the past that either had fees or did not, and that is something that the Legislature has had mixed feeling about. There really has been no clear path of what the preferred method would be, but clearly without any kind of fee associated with a program, the program would be very difficult to implement.

Healthcare Information Division Report: Michael Rodrian, Deputy Director, Healthcare Information Division

The implementation of present on admission (POA formerly CPAA) is moving forward with a couple of notable changes. The reporting system will now accept the same codes that the Federal government accepts, which include new codes. The edit program has been modified so that the new codes are not rejected when they come in. OSHPD has been working with the Federal government and the American National Standards Institute on the codes that be incorporated into the reporting system to insure symmetry in medical reporting and medical data transmission. OSHPD does have a regulation package in process because the regulations have to be changed to incorporate these new codes. The draft regulation package will be presented to the Commission at the December CHPDAC meeting.

Candace Diamond and Starla Ledbetter reported at the last meeting that they have been working very closely with the California Health Information Association (CHIA) on the reporting differences that were noted and are now in agreement. One change that may be incorporated was suggested by Public Health Standards and many facilities, that a blank be accepted in place of the "1." In one of the codes, the "1" is a "not applicable," and they want a blank to be accepted there as well. OSHPD feels this will happen, but this has not been incorporated pending the Federal government's final ruling on this. Follow up information on this issue will be available at the December CHPDAC meeting.

Health Outcomes Center Report: Joseph Parker, PhD

The 2005 Risk Adjusted Mortality Rates from the heart bypass surgery reporting program were distributed to hospitals and by October 29th OSHPD should have any comment letters submitted by the hospitals. A final draft of the report should be to the Director's Office by the end of October and OSHPD hopes to have the report published before the end of the year.

The report includes mortality rates and a couple of new sections showing trend lines over time with regard to the mortality rates and the use of internal mammary artery, which is

an important process measure of quality at the hospitals. OSHPD is also beginning to look at risk-adjusted complication rates as OSHPD is now collecting complications data along with the mortality data. OSHPD wants to expand beyond just looking at mortality for heart bypass surgery patients.

The 2003-2005 Community-Acquired Pneumonia Report is complete and will go out to 370 hospitals within the week for review and comment. At the AB 524 Technical Advisory Committee (TAC) OSHPD presented information showing that the do-not-resuscitate (DNR) order as a risk factor provided misleading results with regard to hospital performance. DNR has been pulled from the risk model and this has resulted in more hospitals being labeled outliers, both better and worse. The distribution is still the same, showing no bias in terms of the numbers that are at either end of the spectrum. It is hoped that by mid December the report will be in the approval process with a publishing target date of January.

The final draft of the Maternal Outcomes Public Report has not been delivered to OSHPD by Dr. Patrick Romano; however, OSHPD has received information which is necessary to start a report with more current information using 2004-2006 data. This report would represent OSHPD's first Maternal Outcomes Report containing two major outcomes measures: risk adjusted third and fourth perineal lacerations and unplanned readmissions. OSHPD hopes to have this report released by the summer of 2008 at which time OSHPD would also release the earlier version of the report by Dr. Romano.

OSHPD is happy to announce that conversations have begun with Dr. David Zingmond, at UCLA, to do a stroke outcomes report which would focus primarily on ischemic stroke and mortality. This would be a full scale OSHPD model where the process and structural measures would be examined as they relate to the outcome measure. OSHPD would do a clinical data reabstraction at a random sampling of hospitals to establish the validity of the risk-adjusted mortality rate; are there actionable procedures a hospital can do to improve their mortality rates, and establish that, move OSHPD would move forward with the model. This will be roughly a two-year process.

Commissioner Fine commented that a large disparity in outcomes would be found resulting from the three-hour intervention that is not applicable to remote and rural areas, or underserved populations that do not understand the urgency of seeking out medical care immediately for stroke symptoms.

Dr. Parker acknowledged this and stated that currently there is no national risk-adjusted model for stroke other than a poorly designed one based on annual percentage rate (APR) and diagnostic-related group (DRG) risk-adjustment. Dr. Zingmond will present some preliminary information to the TAC in November and will be asking for their advice.

OSHPD is considering a departure from the established outcome report by instituting a Hospital Mortality Benchmark Report. One critical way in which this method would differ from the traditional reports is that the 98 percent confidence intervals showing that a hospital was better than expected or worse than expected would not be performed. The three-tier grouping of hospitals would not be used as there will be no extensive validation process, instead hospitals will be listed in quintiles.

OSHPD is considering two models that have already been developed and for which OSHPD has record calculated hospital level risk-adjusted mortality rates, abdominal aortic aneurysm repair (AAA) and congestive heart failure (CHF).

OSHPD recently published the Agency for Healthcare Research and Quality (AHRQ) Volume Utilization Indicators to the OSHPD website. These are sometimes referred to as proxy measures for quality, and OSHPD feels that the public and others benefit by knowing this information.

The PDD validation is going forward. The infield reabstraction of records has been completed. The initial analysis will be present at the November TAC meeting. This represents a reabstraction of medical records to assess the reliability and validity of the coding of present on admission and DNR for Acute Myocardial Infarction AMI patients, community-acquired pneumonia patients (CAP), Percutaneous Transluminal Coronary Angioplasty (PTCA) and Congestive Heart Failure (CHF) patients.

Work continues on adding data elements to the PDD. One recurring comment has been that asking for the physician identifier for all possible procedures is really not going to work, especially with diagnostic procedures. The source of the information is not always going to be clear, so attribution may be difficult.

OSHPD has also been advised with regard to patient address there exist opportunities for errors in data entry, so another source within the hospital should be added to corroborate the data.

The biggest issue with adding data elements is that there is no agreement right now on a definition for the time of hospital admission. So if OSHPD is going to ask for lab values or vital signs within 24 hours of admission, then the time of admission must be defined. This will be difficult because of all the different stamps on the lab sheets don't match and might mean different things. It is probably best to look at when the first vital sign was obtained, that might be the time of admission that might be used.

Patient Profile 2005 Report: Mary Tran, PhD, HOC

Dr. Tran diverged from the meeting Agenda, with the approval of Dr. David Carlisle, Chief Legal Counsel Elizabeth Wied and Chairperson Vito Genna, and substituted the presentation prepared for the National Association of Health Data Organizations (NAHDO), Risk of Mortality and Inpatient Admission for Medical Procedures Performed in Ambulatory Surgery Centers, California 2005, for the Patient Profile 2005 Report.

Dr. Tran presented the study which addresses risk of poor outcomes related to 9 selected surgical and diagnostic procedures, utilizing data linkage to identify cases of inpatient admission and death for the following procedures common to inpatient and outpatient care: hysterectomy, appendectomy, tonsillectomy, cholecystectomy, hernia repair, endoscopy, cardiac catheterization, transurethral resection of the prostate (TURP) and percutaneous transluminal coronary angioplasty (PTCA).

The presentation included results of a formal (multivariate) analysis of risk factors for hospital admission for these patients. For example, patient treated in hospital-associated ASCs were twice as likely to have an inpatient admission with 2 weeks that were patients seen in free standing centers. Also, four-fifths of these post-surgery admissions occurred two or more days after the original surgery. Only 20 percent occurred within the first day.

Summary of Results:

- ASC patients had lower morbidity and mortality rates than hospital inpatients
- Inpatient admission rates varied by procedure
- Most frequent reasons for admission included:
    - Rescue/repair for ASC procedure problems
    - Care for patient comorbidities
    - Follow up treatment for illnesses diagnosed by the ASC

Likelihood of Inpatient Admission:

- Type of ASC:
    - Free-standing ASC patients are half as likely to be admitted
- Other patient characteristics with higher risk of inpatient admission:
    - Male
    - White or African American
    - Having 1+ co-morbidities
    - Payment covered by Medicare, compared with private insurance

Likelihood of Mortality:

- Type of medical service:
    - ASC "visit only" has 1/10 risk of death, compared to inpatient
    - ASC case with follow-up admission has higher or lower mortality, depending on the procedure
        - 2x mortality rate for ASC endoscopies having follow-up admission
- Other patient characteristics with higher risk of death:
    - Male
    - White
    - Having 1+ co-morbidities
    - Payment not covered by insurance
        - Self-pay patients not more likely to be admitted, but 70% more likely to die
        - For some procedures: Payment by Medi-Cal or private insurance

<u>Demonstration of the California Healthcare Atlas II</u>: Michael Byrnes, ITSS

Michael Byrnes presented the California Healthcare Atlas II, which is the culmination of much of the web-based GIS applications. The idea behind the Atlas is that this should be a user friendly application where users of OSHPD data can enter the site and drill

down to a facility or a group of facilities that they are looking for, then retrieve information that OSHPD manages. This represents a wealth of information collected in one location in a more manageable format.

One of the great benefits of this Atlas is that two-thirds of it is comprised of tables and printed text. Most online atlases present map after map but leave out the critically important contextual information. OSHPD has designed this Atlas with a text search so that the full volume of OSHPD data can be search in context, with the maps as a background, for information such as total number of discharges, average costs compared to the facility selected versus statewide. The real intent behind the Atlas was to design a strong user interface that allows the user to access the full set of OSHPD resources which is 80 million records strong and growing by about 20 million annually.

OSHPD designed a suite of workflows for the California Atlas II that are easy for the user to walk through, locate things, select things and create standard products. There are three primary work flows or ways to navigate the Atlas: locate, select, and create. The locate navigation will allow a user to locate any kind of geography and will zoom to the map. The select navigation allows the user to select a certain set of facilities, or an individual facility, and return with the full suite of OSHPD data sets. The create navigation allows the user to create maps, given a whole set of filters, from diagnostic-related groups, race and ethnicity, to payer.

Next Meeting: The next meeting will be held on December 7 in Northern California.

Adjournment: The meeting adjourned at 2:00 p.m.

Pending Items:

1. Presentation of draft regulation package for present on admission at the December CHPDAC meeting.

2. The quarterly report on the status of the study and review of additional data elements charged by the Commission to OSHPD staff.